

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1470 -63-008328

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District 1003

Registrar's No.

STATE FILE NUMBER

FILED FEB 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospital		d. STREET ADDRESS (If outside, give location) 4132 Toenges Ave.	

3. NAME OF DECEASED (Type or print)	First BERTHA	Middle BESTER	Last	4. DATE OF DEATH Month Feb. Day 8 Year 1963
--	--------------	---------------	------	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1883	9. AGE (last birthday) 79	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HR: Hours Min.
------------------	---------------------------	---	--------------------------------	------------------------------	--	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	---------------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Late Joseph Bester
-------------------------------	--------------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) No None	17. INFORMANT Address Bruno Schulz 8703 Rosalie (17)
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage; Generalized Arterio Sclerosis; 331X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour / a.m. / p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	--	------------------------------	--------	-------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
-------------------------------------	--------------	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 13, 1963	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
--	----------------------------	--	--

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.	25. DATE RECD. BY LOCAL REG. FEB 11 1963	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	---	---

VS-300
Rev. 4/59

1

2 20

3

4

5 2

6

7 2

8 2

9

10

11

12 92-3

13

91

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

R. W. Storrsand

Licensed Embalmer No.

4007

P. O. Address

St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.